STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of two State hospital complaints. Complaint Numbers: IN00185178, Unsubstantiated, lack of sufficient evidence. IN00191260, Unsubstantiated, lack of sufficient evidence. Date of Survey: 6/14/16 and 6/15/16 Facility Number: 005051 Indiana University Health is in compliance with 410 IAC 15-1.5-6, Nursing Services, Indiana hospital Licensure Rules. QA: 7/14/16 jlh	S 000		